Maricopa Managed Care Systems

OUTSIDE/HOME SERVICE & CONSULTATION REQUEST
Send Billing to: MMCS Claims
P.O. Box 20019, Phoenix, Arizona 85036-0019

Date:____/____/____

Member ID No.:_____

Name:_____

DOB:____/____/____ Sex:____

PID:_____

Primary Language:_____

Facility Name and/or Contact Person:

PCP:

Member's Address

Patient's Phone:

Phone Message:

FHC:

Emergency Contact Person/Phone No.:

Case Manager: Phone No.:

Vendor Name/Address:

Vendor Phone No.:_____

Vendor FAX No.:_____

Authorization No._____ Effective Date:_____ End Date:_____ Estimated Cost $_____

Service Requested/Consult: **Request for Service <u>MAY NOT</u> exceed 90 days.**

☐ Emergency ☐ Within 48 Hours ☐ 30 Days ☐ 60 Days ☐ 90 Days

DX & medical Justification for Service/Consult: Prognosis ☐ good ☐ fair ☐ poor Height_____ Weight_____

Requesting Physician:_____ Phone:_____

Attending Physician:_____

UPIN/PAS/Provider:_____

MMCS Authorization Unit Use Only:

☐ Perry vs Kelly:

Rate Code:_____ Date Verified:_____ By:_____

☐ ALTCS ☐ MSSP ☐ MCHP ☐ HS ☐ Other_____

☐ TPL_____ ☐ Policy/ID No._____

Medicare Number:_____

☐ Part A Eff Date:_____

☐ Part B Eff Date:_____

Approval Signatures:
Approved by:

Medical Director: